15-0900-16025-2

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS
FOR THE COMMISSIONER OF HEALTH

In the Matter of Whittier Health Center,
Survey Completed 3/17/04

RECOMMENDED DECISION

The above matter was the subject of an independent informal dispute resolution (IIDR) meeting conducted by Administrative Law Judge Beverly Jones Heydinger on Tuesday, November 30, 2004, at 9:30 a.m. at the Office of Administrative Hearings, 100 Washington Avenue South, Suite 1700, Minneapolis, MN 55401. The meeting concluded on that date.

Appearances: Marci Martinson and Mary Cahill, Division of Facility and Provider Compliance, Department of Health, 1645 Energy Drive, Suite 300, St. Paul, MN 55108-2970. Robert F. Rode, Esq., Voigt, Jensen & Klegon, LLC, 2550 University Avenue West, Suite 190 South, St. Paul, MN 55114, on behalf of Whittier Health Center. Matt Bedard, Administrator, Betsy Phillips, Social Worker, and Barbara Stuefer, Director of Nursing at Whittier Health Center, were also present.

NOTICE

Under Minn. Stat. § 144A.10, subd. 16(d)(6) this recommended decision is not binding on the Commissioner of Health. Under Department of Health Information Bulletin 04-07, the Commissioner must mail a final decision to the facility indicating whether or not the Commissioner accepts or rejects the recommended decision of the Administrative Law Judge within 10 calendar days of receipt of this recommended decision.

Based upon the exhibits submitted and the arguments made and for the reasons set out in the Memorandum which follows, the Administrative Law Judge makes the following:

RECOMMENDED DECISION

1. That citation F-224 is supported in part. The violations for Residents 12, 14, 30, 32, 19 and 28 should be upheld; the violations for Residents #11 and 29 should be dismissed. The level of severity should be reduced from K to H.

2. That citation F-241 is supported in part. The Level D violations for Residents 31 and 38 should be upheld; the violation for Resident #19 should be dismissed.

Dated this 8th day of December, 2004.

S/ Beverly Jones Heydinger
BEVERLY JONES HEYDINGER
Administrative Law Judge

Recorded: Tape-recorded
(Three Tapes, No Transcript Prepared)

MEMORANDUM

Citation F-224

Tag F-224 is issued when the surveyors conclude that the facility has failed to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents. The guide to surveyors states that the facility must identify residents whose personal histories place them at risk for abusing other residents, develop intervention strategies to prevent occurrences, monitor for changes that would trigger abusive behavior and reassess the interventions on a regular basis. "Neglect" is defined as the failure to provide goods and services necessary to avoid physical harm, and mental anguish.[1] The surveyors concluded that the facility failed to train staff in the behavior management of residents who displayed aggression, failed to follow and/or revise the facility abuse prevention policy to decrease the potential for resident to resident abuse, and did not implement effective interventions to prevent further incidents.

The surveyors concluded that the violation placed residents in "immediate jeopardy," placing the violation in category "K", level 4. A finding of "immediate jeopardy" requires evidence that the facility's noncompliance has caused, or is likely to cause, serious injury, harm, impairment or death to a resident. There is a "pattern" when more than a very limited number of residents are affected, but the deficiency is not pervasive throughout the facility.

The State Operations Manual (SOM) lists factors to consider in the determination of "immediate jeopardy": "The entity either created a situation or allowed a situation to continue which resulted in serious harm or a potential for serious harm, injury, impairment or death to individuals," and "the entity had an opportunity to implement corrective or preventive measures."

The Surveyors cited instances with eight different residents that it believed supported this citation. In reviewing each one, the ALJ considered whether the resident had been assessed, whether the resident's care plan addressed identified problems and included intervention, whether the appropriate intervention was followed, whether there was a reason to reassess the resident and reconsider the care plan following the incident, and, if so, whether that was done.

The Department demonstrated that there was a violation for 6 out of the 8 residents, as explained in greater detail below. However, it did not present sufficient evidence to warrant a determination of "immediate jeopardy." Some harm did occur to residents. However, the injuries were relatively minor and did not require a physician's care. In most cases, the injuries were scrapes or scratches. Most were easily and quickly treated. It is true that the possibility of injury can create an atmosphere of fear that is harmful, but the Department did not present a sufficiently strong pattern of incidents to suggest that the residents were fearful of their surroundings, or were avoiding contact with others to protect themselves. "Immediate jeopardy" requires a risk of serious harm. The assessments, care plans, and staff attentiveness were sufficient to minimize the risk that serious harm would come to a resident. In fact, there was no serious injury in any one of the reported incidents.

The guidelines do not require that actual harm occur for a determination of immediate jeopardy. However, there was nothing in the reports of the injuries that occurred that would suggest that anything more serious could have occurred. Most of the interactions were brief and quickly resolved, with minimal intervention. If there is a pattern with some injury, but not serious injury or potential for serious injury, it would be more appropriate to assign Level H. Some possible triggers for "immediate jeopardy" are listed on Ex. C-4. Only one out of fifteen of the factors listed for "failure to prevent neglect" has any connection to the facts presented here, "inadequate supervision to prevent physical altercations." Similarly, one of the three factors for "failure to protect from psychological harm" is suggested here, "lack of intervention to prevent individuals from creating an environment of fear."

The Department apparently concluded that the facility had the opportunity to implement corrective or preventative measures. Under the facts of this case, the facility may have needed to review its behavior management plans and triggering events more frequently. But the deficiency called for some improvement in technique and follow-up, not an overhaul in the assessment and case planning process.

Resident #11

The violation should not be upheld. Aggression was identified in the assessments and care plan, with interventions (Exs. 5, 8, 9 (pp 2 –3)). There was no evidence that the interventions were not used. When the fight occurred on 12/5/03 between this resident and another, an incident report was completed, and the cause of the fight could not be determined. There was no obvious reason to reassess or reconsider the care plan following one incident. The Department was concerned that the tracking of the aggressive behavior (Ex. 12) was incomplete, but the other evidence clearly showed that the staff were aware of and managing this resident's aggressive tendencies.

Resident #12

The violation should be upheld. The plan of care update on 9/9/03 reflected that the resident was verbally abusive, raised his voice to staff, got angry, and was manipulative of staff and other residents (Ex. 16, p.2). Target behaviors, including anger, and yelling at others, were tracked (Ex. 20). On 1/27/04, a staff member indicated that Resident #12 had pushed her and yelled at her (Ex. 20, p. 4). There is no IPOC note following up on this. There was a referral to his doctor on 2/24/04 because Resident #12 was being demanding, intrusive, and jumping up into others' faces, but no other reflection that his behavior and interventions were reviewed, or that there were changes to the care plan to reduce this behavior.

Resident #12's behavior was apparently aggravating to others, and ultimately led to Resident #12's roommate throwing things at him and scratching him on February 6, 2004. The Facility moved the roommate to another floor, but there is no evidence that there was any investigation concerning Resident #12's role in the dispute. Another incident occurred on 3/10/04. But there was no evidence that his care plan or behavior management plan were reviewed until after this situation was identified by the surveyors (Ex. 18).

Resident #14

The violation should be upheld. This resident had a history of intermittent explosive disorder, with physical and verbal aggression. He was easily annoyed, both verbally and physically aggressive, and socially inappropriate. All of this was set forth in his care plan, along with a number of approaches to manage him (Ex. H-8). On 2/6/04, Resident #14 hit another resident in the face in the smoking room. Apparently the second resident leaned into Resident #14's space. The Accident Report states that the proposed prevention measures were to encourage others to use a different ashtray and to observe the smoking room more carefully (H-41b). The incident was not reflected on the Target Behaviors Monitoring Sheet (Ex. H-32). On 2/20/04, Resident #14 kicked another resident when that resident apparently bumped Resident #14 with his wheelchair. Staff witnessed the incident (Ex. H-43a). The incident report indicates that the response was directed to the resident who was kicked, to encourage more careful use of the wheelchair (Ex. H-43b). The Surveyors did not feel that either incident was adequately assessed to determine the triggers to the behavior, or whether changes to the care plan were needed.

The Facility's response was that this person's aggression was well-documented, that his explosive behavior was not more likely to occur in the smoking room than other spots in the facility, and that the resident was watched at all times to prevent altercations. In general, he reacted to others being within his "personal space," and was impulsive and aggressive. However, in light of the proximity in time of the two incidents, it was reasonable to expect the IPOC to address the issue, review the care plan, and determine if any changes were needed. There is no evidence that this occurred until the surveyors raised questions (Ex. 26), and no evidence that the suggestions made during investigation of the incident report were moved to the care plan.

Resident #30

The violation should be upheld. Resident #30 was the second resident involved in the fight with Resident #11 on 12/5/03, discussed above. His care plan reflected that he was aggressive, required redirection, and should be removed from other residents' rooms (Ex. L-16). The care plan also stated that his behavior should be carefully monitored during every shift, and his behavior management plan updated regularly (Ex. L-17). His aggressive behavior was discussed, and his behavior data collection and assessment, along with target behaviors, reviewed on 11/7/03 at the quarterly IPOC (Ex. 32, pp. 2-3, Ex. 33), and the note from the meeting refers to the Care Plan for details. The Care Plan also directed staff to monitor aggression on every shift. However, his PATH: Behavior Management Plan of Care – Sheet 1(Ex. L-25) does not reflect aggression. Aggression was not tracked on the Target Behaviors monitoring sheets (Ex. 34).

Apparently the Facility Staff were not able to determine the cause of the fight on 12/5/03. Notes reflect the reason was "unknown." Another incident occurred on 12/7/03. Resident #30 kicked and pushed another resident and pushed a staff member to the floor. A note in the Progress Notes for 1/26/04[2] indicates that Resident #30 was prescribed Ativan for aggressive, agitated behavior (Ex. 30-b). Despite the altercations and change of medication, the IPOC did not meet again until 2/5/04 to discuss Resident #30's care plan (Ex. 33, p.2).

Resident #32

The violation should be upheld. Resident #32 had a history of verbal and physical aggression. This was addressed in his care plan (Ex. M-20). He also needed a cane to help him balance when walking. On 10 occasions from 8/19/03 through 11/22/03, this resident had incidents involving aggression, and 8 of them involved the resident either hitting at, swinging or shaking his cane at others. The involvement of his cane in the aggression was not discussed or addressed in his care plan. The surveyors also noted that the incidents of aggression clustered at times that the facility staff would be busy, but they did not see any documentation that the facility had identified this correlation.

On 11/5/03, staff made a referral to Resident #32's physician to get a prescription to deal with the resident's increased agitation (Ex.M-55), but there is no indication in the file that the team met to review the behavior management plan, or to address the risks to others associated with the resident's use of his cane. The IPOC met on 12/22/03, and the Social Services Progress Notes indicate that the Behavior Data Collection and Assessment was reviewed and approved, and target behaviors identified and discussed (Ex. M-56), but the use of the cane was not addressed.

The Facility asserts that this resident was very closely monitored, and that there was no particular pattern to his aggression. However, it is apparent that the care plan did not deal specifically with the resident's use of his cane as a possible "weapon." The Director of Nursing did not believe that it was in the resident's best interest to take away

the cane because the resident needed it to maintain his mobility. It is not clear if another type of equipment would have worked as well, or whether staff discussed options. Given the pattern of incidents involving this resident's cane, the surveyors reasonably questioned the facility's failure to specifically discuss it, and incorporate steps to minimize its potential risk to other patients.

The incident concerning the resident's request for a cigarette did not seem directly relevant to the violation, although it's possible that the staff's failure to respond directly could have triggered aggression.

Resident #19

The proposed violation should be upheld. Resident #19 was the victim of the incident with Resident #14 on 2/6/04. Resident #19 was hit in the face when he leaned in front of Resident #14 in the smoking room. The incident report suggested that Resident #19 should not use Resident #14's ashtray, but this did not get placed in Resident #19's care plan. The Facility objected to this; ordinarily Resident #19 smoked alone, the smoking room was monitored, and, in particular, Resident #14's smoking was monitored, and the incident did not suggest any need to amend the care plan.

Resident #19 suffered from a traumatic brain injury and a bipolar disorder. His speech was difficult to understand, and he was verbally abusive, socially inappropriate, and quite impulsive. The surveyors were concerned that his behaviors would provoke retaliation by other residents and that the interventions included in his care plan were not improving his behavior.

The facility disagreed that the care plan was inadequate. Because of his impulsive and unpredictable behavior, no one incident would provide useful information about precursors or triggers. The facility did note increased behavior problems and impulsivity. See also the Progress Notes (ex. I-29b-32b). On October 20, 2003, the resident was seen by a psychologist, who recommended a review by Dr. Heefner, and advised: "Con't to set limits as needed for pt's safety and the safety of others." Dr. Heefner reviewed the resident's case on October 26, 2003. His response was: "What behavioral measures are being used to control the above? Doubt the problems are going to be medication responsive. Why do you want neuropsych. testing? I'm not sure how it would be helpful." (Ex. I-34.)

Despite these recommendations, it is not clear from the records that the resident's care plan and behavior management plan were reviewed to determine if more specific interventions or any change were warranted. Admittedly, when they were reviewed in March in response to the survey findings, there were no significant changes made (Ex. 40).

The violation is upheld because the facility did not review the resident's plans when it identified that his aggressive behavior was escalating, and staff and other residents were being threatened. Because of his impulsiveness, it was likely that his behavior would lead to injury to others, or provocation of others to harm the resident.

Resident #28

The violation should be upheld. This resident had a diagnosis of paraplegia, and was identified as very vulnerable, exacerbated by his tendency to be verbally abusive and anxious. He had poor cognition so that reasoning with him was of little value. These characteristics were identified on the MDS (Ex. J-3). His care plan indicated that he became anxious in crowded places, and that he was anxious in the presence of his peers, but it did not include any approaches for dealing with this anxiety. The care plan indicated that the resident was paranoid and easily panicked and agitated. The approaches to deal with this were to monitor his target behaviors, separate him from others when he was agitated, and not to try to reason with or argue with him (Ex. J-7-J-8). His verbal aggressiveness was also identified, and the identified approaches were to intervene when he was yelling or swearing, praise and reinforce positive behavior, and to remain calm and firm (Ex. J-15-J-16).

On 9/25/03, Resident #28 was hit in the mouth by another resident as Resident #28 was getting off the elevator. The progress notes indicate that the writer discussed the interaction with Resident #28, and stressed appropriate communication when another person was in the way (Ex. 47). The incident was investigated, and the identified changes were to keep this resident away from the resident who hit him, to accompany this resident at all times, and to assure that no one got in his way." (Ex. J-32b). On 2/20/04, Resident #28 was near the nurse's station, and bumped into another resident. A staff member attempted to redirect him and told him to ask others to move. He was kicked in the nose by another resident. As a response, the incident report stated that Resident #28 was asked to treat others with respect, although the writer acknowledged that the resident does not respond to direction.

The response was not consistent with the care plan because staff attempted to reason with the resident rather than assuring that he was at a safe distance from others. In addition, Resident #28's behavior management plan did not include his yelling, nor did it address the need to keep him at a safe distance from other residents (Ex. J-35). The Target Behaviors chart for January 2003 did track yelling at staff, other residents and swearing, but reflects that the interventions did not affect the outcome (Ex. J-38). This behavior was not targeted for monitoring on the February 2003 tracking chart (Ex. J-39). It does not appear that any steps were taken to review the plan of care and reinforce the identified strategies with staff in order to prevent additional altercations. The facility indicated that the incident would have been discussed at an IPOC meeting, but there was no evidence that occurred. In addition, Ms. Phillips did not believe that any change in the interventions was needed. Although that could be, in each instance the staff responded contrary to the care plan.

Resident #29

The violation should not be upheld. Resident #29 had dementia and wandered. She could not recognize dangerous situations, and on 12/5/03, she walked between two male residents who were fighting. The surveyors concluded that the facility failed to adequately address the aggressive behaviors of the two residents in the fight, Residents #11 and #30, placing this vulnerable resident at risk. The facility's response, indicated in the incident report, was to keep this resident away from agitated residents (Ex. K-9b). Although this resident was hurt, it is difficult to conclude that a change was needed to her plan of care. Obviously the facility must focus on assuring that other residents do not fight, so that they do not injure each other or innocent bystanders. But that does not directly affect the care plan for this resident. This violation seems entirely collateral to the incident. It is obvious that staff would try to prevent fights and keep all others away from residents who are fighting, even if that were not specifically in each individual care plan.

Citation F-241

Tag F-241 was issued for failure to promote care for residents in a manner that maintains or enhances each resident's dignity. For one of the three residents where violations were found, the surveyors did not believe that staff responded to her concerns appropriately, and, in two instances, surveyors reported that staff spoke harshly to the resident. As discussed more fully below, the Department provided adequate support for two of the three violations, and appropriately assigned them to Level D.

Resident #31

This violation should be upheld. At approximately 7:15 a.m., this resident was pounding her coffee cup on the dining room table, indicating that she wanted a cup of coffee. Two nursing assistants were handing out breakfast trays, and a medication aide was administering medication to Resident #25 who was sitting at the same table. The medication aide told Resident #31 that she would be right with her, but did not direct other staff to get Resident #31 coffee. Another resident at the table requested that someone get Resident #31 some coffee. Resident #31 continued to pound on the table until 7:30 when coffee was poured for her.

Resident #31 had been assessed as consuming coffee before meals with the result that she did not eat properly. She was encouraged to eat before she drank her coffee (Ex. Q-13), and staff was directed to monitor fluids to avoid overconsumption (Ex. Q-15).[3] However, the care plan also stated that the resident should be told when she would be aided if assistance was not immediately available (Ex. Q-18, re: use of vending machines.) In addition, her communication assessment showed that she would repeat the same thing over and over and did not listen to a response (Ex. Q-10b). The Behavior Symptoms assessment indicated that she might sputter and get indignant but could be easily redirected (Ex. Q-11b). The surveyors believed that Resident #31 could suffer more than minimal emotional harm from the staff's failure to respond to her request. Although it may have been appropriate to delay coffee for Resident #31, it was not appropriate to ignore her and allow the banging to go on without attention of the

staff. The facility asserted that ignoring her was appropriate, but that is not the intervention outlined in the care plan.

Resident #38

This violation should be upheld. The surveyor reported that a staff member was rude to Resident #38 while he was waiting for his dinner to be served. In the surveyor's opinion, the resident asked appropriately for his dinner tray, and the staff member's response was loud, curt and sarcastic: "Excuse me! Go sit down and I'll bring it to you when it's your turn." The facility questioned this because the resident is very easy-going and not likely to elicit this type of response from a staff member. However, the surveyor was firm that she clearly recalled the exchange, which occurred over the generally high noise level of the dining area. Since the surveyor could hear the comment in that setting, it is likely that it was louder than would ordinarily be a respectful conversational tone of voice.

Resident #19

This violation should not be upheld. This incident also involved a harsh tone of voice to a resident. However, under the circumstances, it may have been appropriate. This resident was at risk of falling, and had a history of impulsive and angry behavior. He was to be approached in a calm and firm manner. In this instance, the resident was attempting to move a chair to sit at a table (Ex. S-21). The staff member stepped in: "No! Let me do it. I'll move the chair." The surveyor thought the words were fine, but the tone was harsh. Since firmness was called for, and there is a fine line between "firm" and "harsh," there is insufficient evidence to support a violation.

The Department assigned these violations to Level 2, noncompliance that results in no more than minimal mental and/or psychosocial discomfort to the resident. Level 1 is appropriate when the noncompliance has the potential for causing no more than a minor negative impact. These two levels are close, and it is difficult to assess the likely impact of the incidents on the two residents. However, the Department has a reasonable basis for assigning Level 2 because Resident #31 was ignored for so long, and because the comment to Resident #38 was made in the presence of others. Since the incidents were isolated, Level D is appropriate.

B.J.H.

[1] Ex. D-1 – D-4.
[2] The date on the exhibit is partially obscured.
[3] See also Ex. Q-18, limited interest in activities unless coffee is served.